

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  335827	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  10/03/2023
NAME OF PROVIDER OR SUPPLIER  The Grand Rehabilitation and Nrsq at River Valley		STREET ADDRESS, CITY, STATE, ZIP CODE  140 Main Street Poughkeepsie, NY 12601	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0657</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals.</p> <p>45478</p> <p>Based on observation, interview, and record review during a recertification survey the facility did not ensure that comprehensive care plans were reviewed and revised by the interdisciplinary team. This was identified for 1 of 6 residents (Resident # 59) reviewed for accidents. Specifically, Resident # 59 had a fall on 2/4/23 and a fall with injury on 2/28/23 and the Fall Care Plan was not revised.</p> <p>Findings include:</p> <p>Resident # 59 had diagnoses including arthritis, lymphedema, and peripheral neuropathy.</p> <p>The Annual Minimum Data Set (MDS-an assessment tool) dated 8/26/23, documented the resident's cognition was intact. Resident #59 needed limited assistance of one person for bed mobility, transfer, and toileting.</p> <p>The Accident/Incident (A/I) reports dated 2/4/23 and 2/28/23, documented Resident #59 falls when getting up to ambulate with their walker.</p> <p>The fall care plan created 10/7/19, documented the resident had an actual fall related to decreased mobility, depression, psychoactive drug use, and use of psychoactive drug use. It further documented the resident had an actual fall while out on pass on 11/10/19 and on 9/24/21 an actual fall with no injury.</p> <p>There was no documented evidence the fall care plan was reviewed and revised for the falls Resident #59 had on 2/4/23 and 2/28/23.</p> <p>During an interview on 10/03/23 at 3:18 PM, the Director of Nursing (DON) stated the Assisted Director of Nursing (ADON) and DON were responsible for updating care plans. The DON stated when they reviewed the electronic medical record there were no updates made to the fall care plan. The DON stated the registered nurse (RN) that completed the A/I reports should have updated the care plans but did not.</p> <p>415.11 (c)(2)(i-iii)</p>

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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